

North Carolina Department of Health and Human Services  
**Division of Medical Assistance**  
**Daklinza Continuation Prior Authorization Form**

**Recipient Information**

1. Recipient Name: \_\_\_\_\_ 2. Recipient ID #: \_\_\_\_\_

**NOTE: SOVALDI® CONTINUATION PRIOR AUTHORIZATION FORM MUST ALSO BE FILLED OUT**

**Drug Information**

3. **Daklinza** 4. **28** Per 28 Days

5. Length of Therapy (Check ONE):

\_\_\_ **Last 4 weeks of 12** = Genotype 3

Sovaldi® + Daklinza®<sup>1</sup>

**Clinical Information**

1. HCV-RNA (IU/ml) \_\_\_\_\_ and/or log<sub>10</sub> value \_\_\_\_\_ at week 3 or 4 of treatment cycle (must show less than 25IU/ml or 2log<sub>10</sub> reduction in HCV-RNA to continue.)<sup>2</sup>

2. HCV-RNA (IU/ml) \_\_\_\_\_ and/or log<sub>10</sub> value \_\_\_\_\_ **documented on original Prior Authorization**

<sup>1</sup>**For Genotype 3, the Daklinza Continuation Prior Authorization Form must also be filled out and sent in**

<sup>2</sup>**HCV-RNA lab test results MUST be attached to the PA to be approved.**

This form can be uploaded into the secure NCTracks Provider Portal, faxed, or mailed to CSC. If faxed, the Standard Drug Request Form **MUST** be the first page faxed. Fax all forms and lab work to CSC at: (855) 710-1969.

Pharmacy PA Call Center: (866) 246-8505